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Engaged or Divorced? Cross-Service Findings on Government Relations with Non-State Service-Providers

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Summary

Non-state provision (NSP) of basic services is an important substitute for government services in most developing countries. The international policy environment favours the idea that service levels could be improved if government and non-state providers collaborated. This article examines the experience based on studies of basic education and healthcare, water and sanitation in six African and South Asian countries. It finds that, while policy is now generally in support of NSP, practice is more often unsupportive and relationships are surrounded by mistrust. The main providers of non-state services – local entrepreneurs, individual practitioners, community organisations and small NGOs – are largely absent from any dialogue with government. They are exposed to forms of regulation that are largely repressive and effectively designed to protect established interests. Nevertheless, the article identifies positive examples of alternative forms of regulation that advance improved service standards, of facilitation by large NGOs acting in an intermediary role in support of local actors, and of replicable forms of collaboration between government and non-state providers.

Key words: Africa; South Asia; service provision; non-state providers; contracting, regulation

The questions

This article addresses the issue whether governments can engage with non-state providers in ways that increase and improve service provision to poor people. It seeks answers across the service sectors to three questions: What are the explanations of failed or non-supportive relationships? Under what circumstances may positive relationships occur? What are the policy implications? The article draws largely on the six country studies referred to in this Symposium's introductory article (Batley et al 2004, Chowdhury et al 2004, Delay et al 2004, Kadzamira et al 2004, Larbi et al 2004, Moran et al 2004, Nair 2004) and on the other papers in this Symposium.

The importance and variety of non-state provision

Of the six countries covered by the research, non-state provision (NSP) of services to the poorer half of the population is important in all but South Africa. We cannot be confident about its size; one of the strongest indicators of the disengagement of governments from the non-state sector is that in none of the countries was there any systematic information on it. However, our studies were able to obtain some indication of the scale of activity in each country.

In South Africa, although the non-state sector is large in terms of its turnover and employment, its population coverage is small by comparison with that of the public sector and mainly focused on the wealthy population. Half of all health expenditure is in the private for-profit sector which serves less than a fifth of the population; and only just

over three percent of the population attends private schools. By contrast, in Nigeria and Malawi, Christian medical missions provide around 60 percent and 37 percent of healthcare services respectively, and in addition there is a myriad of for-profit providers. Faith-based organisations own the majority of schools in Malawi, although most are funded by the state and are closely integrated into the public system. In Nigeria mission schools were taken over by the state in the 1970s. Private for-profit schools are important in both countries, attend the needs of low-income as well as high income groups, and are growing. In Malawi, they account for about four percent of primary and 40 percent of secondary schools; in Nigeria, the registered for-profit sector accounts for 20 percent of primary schools in some states but there is a huge unknown, unregistered category, said to account for about 40 percent of the children in school in Lagos. Water and sanitation are formally provided by the state, but in Nigeria the majority of the rural population depends largely on household and community provision while, outside the large cities, the majority depend on water tankers, vendors and private boreholes.

The South Asian countries present a similar pattern with a particular predominance of NSP in the health sector. Over two-thirds of Pakistani households use private health practitioners (a third of whom are unqualified); in Bangladesh, the proportion is 88 percent. In India, although there is great variation between states, 80 percent of qualified allopathic doctors and 57 percent of hospitals operate privately, and non-allopathic medicine is almost entirely private. In all three countries the proportions using private health and education services is growing. In Pakistan and Bangladesh, at least a quarter of total school enrolment is in non-state schools, with the proportion reaching 55 percent in urban areas of Pakistan. In the case of Bangladesh, most of these are state-assisted community schools with teachers' salaries paid by government. In the Punjab, Pakistan, two-thirds are for-profit schools which if they are registered receive limited help with tax, land and utility bills. In India too, there are private aided and unaided schools. As in the African countries, the majority of the rural population and around a third of the population of the larger cities do not have access to public piped water, but depend on private water vendors or on tube-wells managed by households, communities, NGOs or (particularly in India) government water agencies. According to the Pakistan Integrated Household Survey, 61 percent of all water systems are self-financed by individual households

Whereas NSP in water and sanitation is largely for the poor and for areas beyond the reach of public systems, non-state health and education services address a broader span of consumers, except in South Africa where they offer mainly élite services. In the other countries, non-state health services are probably as likely to serve the poor as the rich; in Pakistan, even the most 'vulnerable' population was as likely as the better-off to use private healthcare but less likely to use non-state schools (CIET 2003). In Nigeria, Malawi and Bangladesh, although government remains the main provider of primary education to all groups including the poor, non-state schools, particularly the unregistered ones, also serve poor families.

It is clear that NSP offers a spectrum of services in terms of quality. However, it is wrong to assume that the poor choose non-state provision simply for want of access to public services. Surveys in Pakistan have found that users report dissatisfaction with government services and greater satisfaction with non-state provision of healthcare, education and water supply (CIET 2003 and Planning Commission 2003). A report for Enugu State in Nigeria showed that non-state health services were preferred because they were often more convenient, more considerate and cheaper (McClean and Salui

2003); similar findings come from a survey of traditional birth attendants in Malawi (Lule and Ssembatya 1994).

There is a great variety of types of provider. For-profit firms and individual entrepreneurs operate in health, education, water and sanitation, and are often the most abundant but least known category. Faith-based organisations and NGOs appear as direct providers in health and education, more rarely in water supply except as facilitators - though there is a church-based water and sanitation system in Malawi. Community and household provision is most prevalent in water and sanitation, although community organisations often also act as funders and managers of schools.

The policy environment

All six states formally espouse the principle of partnership with NGOs and the private sector. For example, the Nigerian National Policy on Education (1998) 'welcomes the contributions of voluntary agencies, communities and private individuals in the establishment and management of primary schools'. The South African minister of finance noted that 'the private sector is better able to deliver effective services, often because of the dynamics of competition or because it generally has advanced technical or risk management capacity' (Republic of South Africa 2000). In Pakistan, the Poverty Reduction Strategy Paper emphasises the mobilisation of private resources and community participation in education, healthcare, water and sanitation. Indian national plans and sector policies since the 1990s have encouraged public-private collaboration with NGOs in health and education, with private health practitioners, and with NGOs, communities and private firms in water and sanitation.

However, current policy commitments rest on layers of historical experience. While formal policy is now generally in support of NSP, practice at the point of implementation is more often unsupportive. The environment of non-state provision is typically one of policy unreliability and legal instability. The relationship is frequently beset by ambivalence and mutual mistrust, built on histories of policy change and rivalry. Underlying this is a real struggle for territory and for the control of scarce financial resources.

A typical sketch history of state/non-state relations in service provision would go through the following stages:

- A colonial period in which mission hospitals and schools were introduced for the indigenous population, combined with privileged government provision of health and infrastructure services for the colonial administration
- An immediate post-independence assertion of the role of the state, leading to the establishment of state water supply and sanitation systems and, in cases such as Nigeria, Pakistan and Bangladesh in the 1960s and 1970s, to state expropriation of private and faith-based providers of education or, as in Malawi, to their incorporation through state funding. State health services were established but elite private provision also grew in the post-independence period.
- Through the 1980s and beyond, the deterioration of public services and the inability of governments to maintain public spending. Most of our country studies describe a period of real decline in the quality of services and an increasing tendency for users to find their own solutions in private provision. A new low-income private commercial sector burgeoned to fill the gap in state provision.

- The 1990s until the present can be characterised as a period of at least formal recognition of the case for 'partnership' with NGOs and the private sector, a policy which has been strongly backed by donors. Some governments – such as Nigeria and Malawi – have raised the possibility of churches re-adopting and funding schools and hospitals. In Pakistan, some schools were handed back to their previous owners in the 1980s and religious organisations were encouraged to take on new roles as service providers.

The strongest lurches in the policy environment – from state takeover, to severe public service decline, through the incremental growth of market provision, to the advocacy of partnership can be seen in Nigeria and Pakistan. India, though reflecting all of these stages, shows a greater continuity - with the state remaining pre-eminent throughout but never acting wholly to suppress non-state provision. In Malawi, a similar pattern is mediated through the persistent relationship between the state and church provision, especially but not only in health and education. Bangladesh is characterised by the large scale of NGO activity, and by a small number of very large NGOs that work across sectors and channel donor funding to smaller organisations, in systems that have a high degree of autonomy from government. South Africa is, at the other extreme, where post-apartheid governments have been committed to the strengthening of government-run public services and have been able largely to achieve this; here non-state provision for the poor is largely an adjunct to the public service.

Even in the most institutionalised case – the relation between church and state in health and education provision in the African countries – there has been a constant shift in the rules of the game between collaboration, laissez-faire, incorporation and control. Probably the greatest ambivalence has been in the education sector where the state has sought but failed wholly to assert its dominance. In the health sector, given its complexity and multiplicity of providers, there was never a serious claim to universality of state provision. In water and sanitation, urban piped systems remain very largely under the control of public authorities, even if some provision is contracted out; wholly non-state provision is extensive in rural and poor urban areas, but not a preferred alternative.

Policy dialogue

Informal dialogue was always present in these policy environments. The survival and recent growth of the non-state sector has involved on-going interaction between government and NSPs. No doubt deals were done, permissions explicitly or implicitly given, relationships cultivated, mutual obligations and political or personal gains negotiated – often not at policy level but in trade-offs at the point of implementation. The Pakistan study describes 30 years of collaboration between the government of Azad Jammu and Kashmir with two NGOs (the Family Planning Association of Pakistan and the Marie Adelaide Leprosy Centre) in which the two sides slowly built up relations of confidence. A more nefarious sort of dialogue is thought to be maintained between associations of water tanker owners and city authorities in Karachi and Lagos to maintain inadequate piped water supplies.

Associated with the principle of partnership is *formal* 'policy dialogue', a phrase that is most evident in donor-dependent countries. Donors, the World Bank and UN agencies advocate the participation in policy-making of civil society actors so as to maximise its reflection of the poor's priorities. Specifically in relation to service provision, the idea is that complementarities can be found between the roles of government and non-state

providers (Wakefield 2004). Donor-inspired policy instruments such as poverty reduction strategies, the Education for All and Health for All agendas, and sector-wide approaches at national level have created frameworks for more open policy dialogue.

The country studies show that formal opportunities for dialogue have indeed increased. However, as the articles by Palmer, Rose and Sansom in this Symposium indicate, these new more open encounters are often in practice limited in three senses. First, they take place at the policy design stage in set-piece events rather than in continuous interaction over policy implementation. Second, they often involve NSPs very cursorily. Thirdly, they typically include primarily the larger NGOs which have capacity to represent themselves in such events. A recurring theme is that large NGOs have taken advantage of donor processes to initiate dialogue and lobby for influence. Service providers have sometimes set up umbrella associations to represent their interests, but generally local level community organisations and individual entrepreneurs have little if any representation in such events. However, even where the formal dialogue remains limited, it can be argued that the promise of partnership and of participation in policy formation has contributed to a restructuring of the non-state sector's relations with government, excluding some but creating new levels of organisation among others.

Often the key participants in dialogue are organisations set up to act as advocates for the rights of the poor. For example, in direct response to donor language, in Bangladesh a Centre for Policy Dialogue was established, and in Nigeria a Grand Alliance for Poverty Reduction and a Civil Society Coalition on Education For All. In India, civil society engagement in policy dialogue is primarily by advocacy groups. Indeed, service providers are rarely the principal partners in dialogue forums and, where they are present, it is usually narrowly to defend their own interests rather than really to engage in policy dialogue. Umbrella organisations have been set up specifically to take on this role, including, for example, associations of private schools in South Africa, Nigeria, Malawi and India, an association of unregistered schools in Nigeria set up to resist the private schools' lobbying for their closure, and a national association of medicine dealers in Nigeria.

There are some positive but exceptional cases of high level policy dialogue. Palmer (in her article in this issue) cites national consultation processes on health policy in Nigeria, South Africa and Bangladesh which involved non-state providers. However, there was little evidence that high level planning had influenced policy as implemented.

The regulatory framework

Regulation provides the basis on which non-state service providers are prohibited, permitted or encouraged to operate. Broadly, there are two sorts of regulation: those that seek to suppress non-state activity and those that seek to promote its more efficient operation. Our research found a complex reality: governments argue for partnership while deploying regulations that are suppressive, but on the other hand the regulations are rarely actually applied. This creates a realm of uncertainty in which non-state providers operate without security or incentive to invest. This section outlines the main features of regulatory experience, and then identifies the features of relatively good practice.

In health and education, regulation largely applies at the point of 'entry', in other words it is about the conditions under which providers register to practice. In the case of water

and sanitation, independent private provision is rarely formally recognised: if there is any regulation at all, it is about standards of practice rather than qualifications to practice.

Registration procedures for private schools are always elaborate and onerous, while regulation of the public sector is often less severe. Rose's article in this Symposium identifies 'multiple layers of accountability' in South Africa and multiple fees to different authorities in Nigeria. In all countries, the requirements for registration focus on inputs rather than the quality of educational outputs. Kardar (2001) has described the complexity of the private school registration requirements in Pakistan, and their irrelevance to any real concern with the quality of education. They require multiple information on school facilities and equipment (number of maps, blackboards, steel and wooden cupboards etc) but set and measure no standards of teaching quality. They rule on the level of fees and salaries, in spite of the fact that this is a highly competitive sector. In all countries, without registration, school students cannot sit the government matriculation exams. The opportunities for rent-seeking through harassment are high. Characteristic of registration requirements, in countries including South Africa, India, Pakistan and Bangladesh is that they restrict competition with the public sector: non-state schools must maintain a certain distance from or get the permission of government schools.

In the health sector, registration of practitioners is delegated to professional associations which effectively maintain barriers to entry, but leave untouched the much larger number of unqualified practitioners. In India, as elsewhere, state medical councils manage accreditation of individual practitioners but, in most states, there is no registration or regulation of private and voluntary hospitals or clinics. After registration, there is little attempt by professional councils to enforce standards or apply sanctions, and governments have rarely intervened to supervise professions' regulatory practices. Professional councils act generally to defend members' interests rather than the public interest. Exceptions were the pharmacy councils of South Africa and Nigeria which, subject to statutory requirements, have both achieved effective regulation of drug dispensaries.

Whether there is elaborate and inappropriate *entry* regulation as in education or little if any in the case of water and sanitation, monitoring and control of the quality of *performance* is largely absent in all service sectors, except in South Africa. Entry standards have the effect of restricting formal permission to operate, and therefore also access to markets, subsidies and donor funding, but they rarely set a practicable basis on which standards of operation can be assessed. The non-state providers that are approved are then able to operate without regard to quality of output, while the unapproved continue to operate in any case. Apart from the inappropriateness of the rules, their non-application can be attributed to a combination of

- The difficulty of assessing standards of operation of many small and often informal providers. On a scale of practicality, large-scale operators of water supply systems, hospitals and schools might be more easily regulated but even these are usually immune.
- Incapacity of governments to regulate. As the earlier articles by Rose, Palmer and Sansom have shown, regulatory organisations generally lack staff, skills, enforcement powers, or information on the sector to be regulated.
- The resistance of providers. In India 'powerful medical lobbies have opposed the government's efforts to regulate' (Nair 2004:15). In Nigeria, provider associations, particularly in the water sector, were too powerful to control; approved schools

- lobbied for unapproved schools to be closed while an association of unapproved schools successfully used political influence to resist this.
- Avoidance by providers. In the face of burdensome rules, providers ignore regulations or circumvent them often finding it preferable to remain unrecognised. Where necessary, they manage to reconnect with the system, for example by sending children to recognised schools for public examinations.

Bad regulation is worse than none. On Pakistan, Kardar (2001:8) concludes: 'Mercifully, the enforcement mechanisms are weak'. On Bangladesh, Delay et al (2004) conclude: 'One positive aspect of the lack of regulation is that non-state activities have more room in which to provide and to innovate'. However, our studies did find some relatively positive cases of government regulation, and some effective alternatives to it.

South Africa's process for registering NGOs adopts a model 'light touch' approach, in a conscious effort by the government to move away from the use of registration as a controlling device under apartheid. By comparison the Bangladesh NGO Affairs Bureau has powers (but not the human resources) to register, monitor and oversee all NGOs that receive foreign funding; although it lacks the human resources to fulfil the task comprehensively, the powers present the possibility of control.

South Africa also offers examples of 'regulation by facilitation' (using incentives rather than penalties - see Palmer) across the health and education sectors. Registration and the monitoring of quality standards are rewarded by access to subsidies for primary schools and by continuing professional development for pharmacists. Another positive example of the use of incentives for regulation is the award of vouchers to pregnant women for use with accredited birth attendants in Bangladesh. Blantyre Water Board in Malawi supports the development of community water services but at the same time regulates them. However, the use of incentives (subsidies, tax waivers, land, training, etc) for registration can also draw service providers into systems of dysfunctional regulation. There is a possible link between large incentives and heavy regulation: Kerala State in India offers large subsidies for study in private schools in return for quality control, while Madhya Pradesh, Rajasthan and Tamil Nadu are withdrawing grants-in-aid and removing restrictions on opening schools.

Negative, anti-competitive regulation seems most often to occur in services where there is a direct government service to protect. It is noticeable that the most positive cases of effective regulation occurred in regard to drug vending, in which government has no direct stake, in South Africa and Nigeria. These also illustrate the case for the establishment of dedicated regulatory agencies that are at least semi-autonomous from government. In both, a government agency (the Medicine Control Council in South Africa and the National Agency for Food and Drug Administration and Control in Nigeria) has the statutory role of licensing drugs, while an independent pharmaceutical council supervises the licensing and monitoring of private drugs vendors.

There are other models of effective regulation where the regulator has been divorced at least partly from the interests of the providers and also any predatory interest of government:

External accreditation: The Pakistan Centre for Philanthropy has developed a certification regime for non-profit organisations. It sets standards of good internal governance, transparent financial management and effective programme delivery

assessed by an independent panel. The purpose of its voluntary accreditation system is to strengthen the civil society sector by bridging the information and credibility gap that may exist between donors and recipients; but, of course, it tends to favour larger, formal organisations. In Mumbai, India, a Health Care Accreditation Council has been set up to establish quality standards for small private hospitals, with representatives of owners, professional bodies, consumer organisations and NGOs.

Franchise: In some cases, national NGOs act effectively as regulators of the quality of services provided by local level service deliverers. Social Marketing Pakistan offers family planning and reproductive health services by franchising private clinics and pharmacies which have the right to use the 'Green Star' franchise brand if they undergo training and maintain standards. Similarly, BRAC in Bangladesh sub-contracts local NGOs to deliver non-formal primary education programmes funded by donors, offering technical support and training and monitoring the sub-contractors' progress.

Community control: There are many examples where communities or client-users have become part of the process of regulation and monitoring of the performance of service providers. The Orangi Pilot Project in Karachi puts local sewers and water tanks under the direct financing and control of community groups, and subjects contractors to community monitoring. The BRAC model of community controlled schools, in Bangladesh, has been adopted also in Pakistan in community schools supported by the Aga Khan and the National Rural Support Programmes, and in Malawi where the Save the Children Fund involves communities in the recruitment and discipline of teachers. However, Rose (in this Symposium) points out that, while local accountability seems to produce better results in school performance, it also presents dangers of local élite capture.

Privatising regulation: The mayor of Jaranwala in Pakistan recognised the capacity limits of the municipal authority and engaged a private company to monitor the performance of other firms contracted to do local level works, such as drain-clearing.

Facilitation of non-state providers

There are scarce examples of sustained and effective government support for non-state service provision through, for example, finance, training, technical advice, or mobilisation of communities. Where such facilitation does function effectively it is often funded by donors, and operated not by government but by large NGOs. This is not surprising, given that most non-state provision has occurred in spite of or in the absence of government.

In undertaking this research, we met widespread puzzlement on both sides at the idea that government might facilitate the non-state sector. Non-state providers regarded government with distrust and scepticism; governments usually felt that any available funding or support should go to state provision.

In numerous cases where donor support has been channelled through government to NGOs or community organisations, resentment has grown up between government agencies obliged to part with the funds and the recipient organisations that fear the funding is being badly managed or at risk of being diverted. In Pakistan, semi-governmental agencies set up with government endowments to allocate donor funding – such as the National Trust for Population Welfare, and health and education foundations – have rapidly dissipated their funds in an environment of bureaucratic management and

political intervention to the point that some can scarcely cover their own operating costs. Non-state providers dependent on government for funding, even when the resources originate with donors, typically experience great uncertainty. Where donor funding lapses, so too does the government facilitation - for example, of family planning association clinics in Pakistan and Malawi. In Nigeria, direct government support has proven almost wholly unreliable: the mission schools and hospitals were first absorbed by government before then losing their grants and salary subsidies in the 1990s.

Nevertheless, there are some cases where government support has helped NSPs to deliver a sustained and significant service to poor people, without donors taking the lead. The Government of Malawi has maintained a continuous relationship of mutual support with the Christian mission hospitals. In Bangladesh registered non-government primary schools covering about a quarter of total enrolment receive government support in construction and equipment, training and salary payment of teachers. The State of Kerala, which has the highest proportion of private primary schools in India, has deliberately promoted competition in the education sector by providing scholarships and transportation subsidies that allow parents a real choice between private and public primary schools.

However, the evidence of our six country studies is that large NGOs are better able than government to support service provision at local level, where this involves community contributions to the construction or management of facilities. Some have been able to sustain long-term relationships of trust with communities. Donors have often chosen to fund services through NGOs after having bad experience of funding through government.

Large NGOs operating nationally have often mediated between donors or government and communities by working through affiliated local NGOs. Also in Pakistan, the Orangi Pilot Project has developed a model in Karachi that has been replicated in poor urban areas throughout the country: NGO facilitators support community groups in the development of low cost sewerage systems with the collaboration of public utility companies. In Bangladesh, BRAC's non-formal primary education programme serves the most hard-to-reach population (with a particular focus on girls) operating largely independently of government. Directly and through sub-contracted local NGOs, BRAC supports community-managed education centres, recruiting and training teachers and monitoring their performance. In India, the Self-Employed Women's Association facilitates community-based health insurance for the poor by mediating between communities and formal insurance companies. In several of these cases, large NGOs have piloted forms of service delivery that have then been adopted and replicated by government.

Contracting and collaboration

We will use three criteria to distinguish types of contract or agreement which are relevant to all services:

1. organisational relationships range from loose understandings through formal agreements to tight contracts
2. relationships may be hierarchical, where one partner acts as the agent of the other, or collaborative, for example in joint ventures or co-production
3. the non-state provider may be financial autonomous or dependent.

Once again, positive experience is rather scarce.

Tight, hierarchical contracts: Unclear specification of contractual requirements and poor monitoring by government apply even in the two stronger states – South Africa and India – and even in the water sector which should be more easily specifiable than health and education services. Requirements of water provision are relatively easily determined, quantified and measured by comparison with the more qualitative outputs of healthcare and education (Batley and Larbi 2004). However, in India, public-private water concession and franchise arrangements have largely failed or been abandoned in the face of weak political support, lack of contracting capacity and the non-viability of the terms offered to private providers. In South Africa, the Blue Dolphin water concession case was more positive – with strong political support and legal backing – but the local government managing the concession lacked the capacity to regulate the private contractor.

More common were *loose but hierarchical agreements* where, in principle, the government was contracting a non-state partner but the 'rules of engagement' were unclear, not fully expressed in contractual terms, or not respected. The Riveroaks concession in Nigeria is producing cheaper water for more poor people in the Karu-Mararaba area, but it was awarded without competition and is based on an unwritten understanding which leaves the powers of the regulator and the company unclear. In Pakistan, an important innovation in contracting out the management of 140 schools with 97,000 pupils in Lahore to a local, private welfare trust (CARE) achieved a major improvement in schools' infrastructure, numbers of teachers, and performance of teachers and pupils. However, CARE was plagued by lack of control over government teachers in the absence of a clear agreement with the Lahore city authorities. The question is whether arrangements with such in-built tensions are sustainable.

There were also problems with *loose agreements for collaboration* where the partners operate on the basis of complementary contributions but without any clearly stated obligations. A major case is the relationship between the Government of Malawi and the Christian Hospitals Association of Malawi (CHAM). The government is reliant on CHAM to provide services in areas where there are no government hospitals; CHAM depends on government to fund staff. They have operated for decades in principle on the basis of trust, but in practice clouded by suspicion about the fulfilment of obligations, sources and amounts of funding, and the relative benefits of government and CHAM officials. In Malawi, as in several other African countries, this has led to moves to establish transparent service agreements.

The CHAM service agreements are an attempt to 'tighten' the understanding between government and the hospitals about what services should be provided at what level of user fee (or free), in return for government payment of salaries. This is a move from a loose partnership towards a tighter and more hierarchic contract, recognising the hospitals' financial dependence. Similarly, the South African national and provincial departments of health are seeking to move towards a more formalised agreement with the many (around 800) home-based care organisations that support people with HIV/AIDS. The HBC providers are mainly NGOs and community groups but also faith-based organisations and hospices; many are small, informal and voluntary, receiving most of their funding from the state. Government has tried to formalise the arrangement, normally expecting HBC providers to have a clear legal status, and creating a standard contract and guidelines for their organisational structure and functioning, in order to

guarantee a proper standard of service. However, in both the CHAM and HBC cases, tightening the contractual arrangements has a consequence in putting new burdens on limited state capacity to monitor contract fulfilment and, in the HBC case, in making it difficult to include informal providers.

Donor-led projects provide several successful examples of tight hierarchic contracting, but often only for the duration of the project – given that normal systems are bypassed and funding depends on donors. For example, the Asian Development Bank has funded an urban primary health care project that covers the slums of the four main cities of Bangladesh managed by a special project implementation unit in Dhaka City Corporation. A competitive contracting process led to the drawing up of nine performance-related contracts with NGOs. An effective monitoring system was set up, and performance was found to improve in terms of cost, quality, coverage and accessibility of services. The city corporations participated in the process, but there was little direct capacity-building, and the second stage of the project seems likely to proceed on the basis that government will contract an implementing agency, rather than directly contract the providers. In Bangladesh donors have placed more faith in institutionalising and scaling-up non-state service delivery through umbrella contracts to major NGOs, and particularly to BRAC for non-formal primary education.

Tight, hierarchic contracting seems to work under special conditions: the contractual terms are clear, there is capacity of design and implementation on the part of those who award and hold contracts, there is adequate trust between the two parties, the contract awarder controls the sources of funding, and the contract holder has a clear legal status. An alternative is collaborative partnership, which depends on accumulated social capital but is technically less demanding. Here government and non-government partners make separately funded contributions and neither stands in authority over the other. We will briefly describe two possibilities: joint venture and co-production with communities, distinguishing between these on the basis that

- a joint venture is a formal agreement (memorandum of understanding or contract) between formally constituted organisations
- co-production with communities is an informal agreement between formal organisations and communities or service recipients¹.

Two cases that may be described as joint ventures are described in the article by Palmer. The Government of Azad Jammu and Kashmir (AJK), in Pakistan, collaborates on the basis of memoranda of understanding with two large, national, but internationally connected, NGOs: the Family Planning Association of Pakistan (FPAP) and the Marie Adelaide Leprosy Centre (MALC). The collaboration was initiated by the NGOs and partly funded by the World Bank, but the government and the NGOs also brought their own financial and human resources. The NGOs provide services, support and develop government staff, and operate through government facilities rather than setting up rival systems. Each party is powerful enough to retain its autonomy. In India, there are examples of collaboration between state governments, donors, international and national NGOs together with community organisations to provide local level water and sanitation services. Tripartite agreements have been made where donors and international NGOs provide funds and technical expertise; the state government provides funds and policy

¹ We recognise that this is a more limited and specific definition than used by Ostrom 1997 for whom the central point of co-production is that no single principal is in control of all inputs to produce a service output, that production involves multiple public and private agencies including recipients/citizens.

and administrative support; local NGOs support communities in construction; and community water and sanitation committees take on management and maintenance.

Water and sanitation are rich in cases of co-production with communities of service recipients, and can present possibilities of scaling-up. One of the best known cases is the Orangi Pilot Project (OPP) in Pakistan, where public utilities provide large sewers in agreement with community lane committees fund and develop local sanitation systems, facilitated by an experienced local NGO. The model has been replicated from Karachi to some other cities, usually with the support of the originating NGO – the OPP's Research and Training Institute. In Bangladesh, an NGO - the Village Education Resource Centre (VERC) - also without offering subsidies, has facilitated the extension of sanitation in villages by helping to make people aware of health issues; community groups build and maintain latrines; and local entrepreneurs make slabs and plastic pans using moulds provided by VERC. This model has been replicated by other NGOs, and the government has advocated the approach to local government. In other countries – Nigeria and Malawi – schemes exist where the government jointly funds the development of water and sanitation facilities with local community associations which contribute funding and take on the ownership and management of water and sanitation facilities – but these depend on donor support and on the capacity of government to undertake the facilitation role.

What is distinctive about the Pakistani and Bangladeshi cases of co-production is that they seem to offer greater promise of scale and sustainability for three main reasons: they do not depend on external subsidy, the schemes have become institutionalised in the practice of local NGOs, and they are scaled-up not through large organisational structures but by replication of a model. The fact that the strongest examples of community co-production exist in water and sanitation probably relates to the fact that infrastructure has relatively lighter professional maintenance and management requirements by comparison with health and education, and local level systems are technically not complex. Moreover, everybody in a neighbourhood has day to day experience of water and sanitation (deficiencies) in a way that is more pervasive than in the case of the other service sectors.

Policy conclusions

Non-state provision of basic services is a large and often predominant fact of life for poor as well as non-poor people. In some respects, donors' widespread concern with 'scaling-up' seems a little off-track: NSP already fills much of the gap in the quantity if not quality of state provision. At least until government can provide more comprehensive and better services, what needs greatly to be improved is the level of collaboration between government and NSP.

It is not enough for donors to seek policy statements of governments' readiness to collaborate with the non-state sector; such statements are readily forthcoming. Formal policy dialogue typically engages at the level of policy design in set-piece events with large NGOs and advocacy organisations. The direct providers of services to the poor: community organisations, small NGOs and entrepreneurs are largely excluded from such events. What is missing is engagement between government and the non-state sector at the operational level; this is where the history of distrust and rivalry frustrates policy intent.

There are cases of effective (pro-service) regulation by government but the general lessons are that it can only work where the regulator has information, is capable of enforcing standards and has no incentive to repress non-state providers, and where providers have incentives to comply. Government regulation is only desirable when it is slimmed down and re-directed from the control of service inputs to monitoring and supporting the quality of outputs. Awareness and capacity to regulate in this positive sense need to be developed. More likely alternatives to government regulation, particularly where capacity and understanding are limited, are external accreditation, contracted out regulation, franchise of local providers by NGOs and private firms with a reputation to defend, and community monitoring.

Governments may be able to create a facilitating environment for non-state provision at a very broad level - with stable legal frameworks and access to generic subsidies for salaries and other core costs. But where it comes to working empathetically with communities and reacting sensitively to local realities, the more likely model is of large NGOs mediating between government/donors and local NGOs/CBOs, and offering technical support to the latter.

Tight contractual arrangements between government and non-state providers present challenges to government's capacity for contract design and implementation, and tend to rule out the local and informal providers that are often most important to poorer people. On the other hand over-loose partnerships create confusion and conflict about roles and responsibilities. Joint ventures of government with non-state providers and co-production with service recipients present the possibility of clearly stating the roles of the partners without subordinating one to the other. They allow the scaling-up organised service provision, not by creating massive organisations but by disseminating replicable models of collaboration.

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